Fear Avoidance Beliefs Questionnaire (FABQ)

Description

The emergence of the biopsychosocial model of low back pain (LBP) led Waddell et al (1993) to develop the Fear Avoidance Beliefs Questionnaire (FABQ). The FABQ assesses patient beliefs with regard to the effect of physical activity and work on their LBP. It consists of 16 items and patients rate their agreement with each statement on a 7-point Likert scale (0 = completely disagree, 6 = completely agree). The original factor analysis revealed two subscales: the work subscale (FABQw) with 7 questions (maximum score = 42) and the physical activity subscale (FABQpa) with 4 questions (maximum score = 24). A higher score indicates more strongly held fear avoidance beliefs. It takes approximately 10 minutes to complete.

Reliability and validity Test-retest reliability of the FABQpa is acceptable (ICC = 0.72 to 0.90) (Pfingsten et al 2000, Chaory et al 2004). The test-retest reliability of the FABQw is high (ICC = 0.8 to 0.91) (Holm et al 2003, Staerkle et al 2004). The total FABQ has excellent test-retest reliability (ICC = 0.97) over a 30-minute period (Kovacs et al 2006). The FABQ correlates with measures of disability (eg Roland and Morris Disability Questionnaire) (correlation coefficient FABQ 0.52, FABQw 0.63, FABQpa 0.51) and with another measure of fear-avoidance (Tampa Scale of Kinesiophobia [Kori et al 1990] correlation coefficient FABQw 0.53, FABQpa 0.76) (Crombez et al 1999; Kovacs et al 2006). The FABQw is related to length of time off work (Fritz and George 2002).

Commentary

The FABQ is a useful questionnaire to assess fear avoidance beliefs. The psychometric properties of the subscales are better established than the total FABQ so use of the subscales may be preferable. The FABQpa may be more appropriate for patients who do not work. However, Kovacs et al (2006) suggest there may be a ceiling effect for the FABQpa as 23.9% of their sample scored the highest score possible. This was not seen for the total FABQ or FABQw.

The majority of reliability and validation studies have been undertaken in chronic LBP populations but recently there has been interest in its ability to predict long term disability in acute populations. Results have been contradictory in this area with some studies showing that it can be used to identify acute low back pain patients at risk of poor outcome (Fritz and George 2002) but others have shown it not to be a useful predictor in this patient group (Grotle et al 2005).

At present there are no values to define what constitutes an elevated FABQ score. Crombez et al (1999) suggest that a FABQpa > 15 (based on the median score of the population studied) should be considered an elevated score but this requires further validation. Fritz and George (2002) found that a FABQw > 34 identified patients at risk of not returning to work four weeks post injury in patients with acute work-related LBP. However these authors emphasised that more research is needed to establish cut off scores for 'at risk' patients. Establishing such values would improve the usefulness of the instrument in the clinical setting.

The change in FABQ scores that reflects a clinically important change in beliefs has not been established. Changes in FABQ have been shown to correlate with changes in disability following treatment (Woby et al 2004) indicating a relationship between the two. Further research in this area may help to explain patient responses to treatment.

The role of fear avoidance beliefs in the development of long term disability has been gaining importance in recent years. It is important that this psychological factor is assessed so that treatment can address unhelpful beliefs that may contribute to the development or maintenance of disability. The FABQ is a reliable and valid measurement that can be used for this purpose although further research into its use as a diagnostic tool is warranted.

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References

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